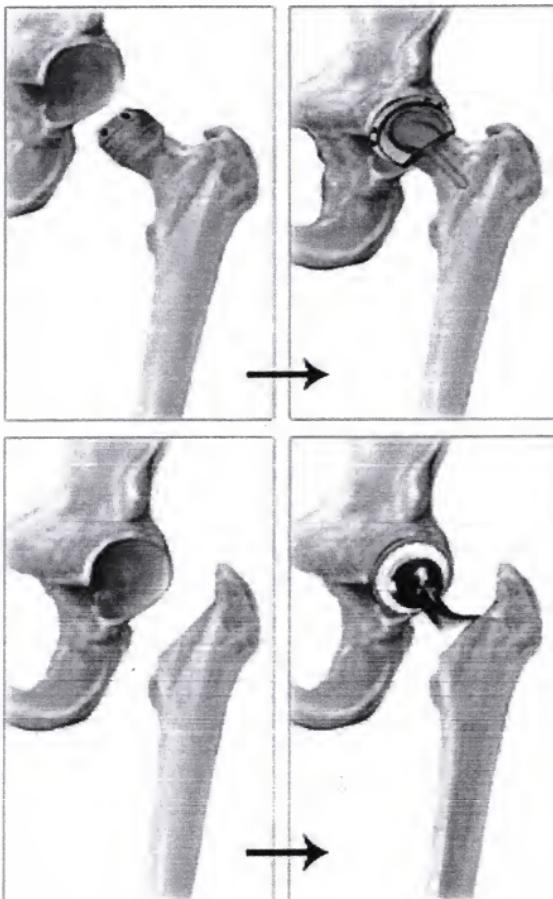


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FOR AN INTERACTIVE DEMONSTRATION OF THE SURGERY GO TO:
<http://www.edheads.org/activities/hip2/>

Comparing Hip Resurfacing with Total Hip Replacement



Patient Information from Your Orthopaedic Connection

Meniscal tears

What is the meniscus?

One of the most commonly injured parts of the knee, the meniscus (meh-nis'-kuss) is a wedge-like rubbery cushion where the major bones of your leg connect. Meniscal tissue curves like the letter "C" at the inside and outside of each knee. A strong stabilizing tissue, the meniscus helps the knee joint carry weight, glide and turn in many directions. It also keeps your femur (thighbone) and tibia (shinbone) from grinding against each other.

Who is at risk?

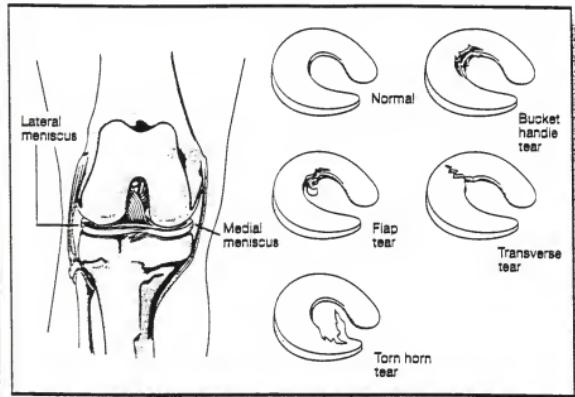
- Football players and others in contact sports may tear the meniscus by twisting the knee, pivoting, cutting, or decelerating. In athletes, meniscal tears often happen in combination with other injuries such as a torn anterior cruciate ligament (ACL).
- Older people can injure the meniscus without any trauma as the cartilage weakens and wears thin over time, setting the stage for a degenerative tear.

Signs and symptoms

You might experience a "popping" sensation when you tear the meniscus. Most people can still walk on the injured knee and many athletes keep playing. When symptoms of inflammation set in, your knee feels painful and tight. For several days you have:

- Stiffness and swelling.
- Tenderness in the joint line (where the thighbone meets the shinbone).
- Collection of fluid ("water on the knee").

Without treatment, a fragment of the meniscus may loosen and drift into the joint, causing it to slip, pop or lock—your knee gets stuck, often at a 45-degree angle, until you manually move or otherwise manipulate it. If you think you have a meniscal tear, see your orthopaedist right away for diagnosis and individualized treatment.



Diagnosis

Tell your orthopaedist exactly what happened and when. He or she may conduct physical testing to evaluate the extent of your meniscal tear. You may need X-rays to rule out osteoarthritis or other possible causes of your knee pain. Sometimes your doctor may use a magnetic resonance image (MRI) to get a better look at the soft tissues of your knee joint. Your orthopaedist may also use a specialized instrument (arthroscope) to see into your knee joint, especially if your knee locks.

There are several kinds of meniscal tears:

- Young athletes often get longitudinal or "bucket handle" tears if the femur and tibia trap the meniscus when the knee turns.
- Less commonly, young athletes get a combination of tears called radial or "parrot beak" in which the meniscus splits in two directions due to repetitive stress activities such as running.
- In older people, cartilage degeneration that starts at the inner edge causes a horizontal tear as it works its way back.

Conservative treatment

Initial treatment of a meniscal tear follows the basic RICE formula: rest, ice, compression and elevation, combined with nonsteroidal anti-inflammatory medications for pain. If the knee is stable and does not lock, this conservative treatment may be enough. Blood vessels feed the outer edges of the meniscus, giving that part the potential to heal on its own. Small tears on the outer edges often heal themselves with rest.

Surgical repair

If the meniscal tear does not heal on its own and the knee becomes painful, stiff or locked, you may need surgical repair. Depending upon the type of tear, other injuries, your age and other factors, your orthopaedist may trim off damaged pieces of cartilage during arthroscopic surgery.

A cast or brace immobilizes your knee after surgery. You must complete a course of rehabilitation exercises before gradually resuming activities.

PATIENT EDUCATION GUIDE

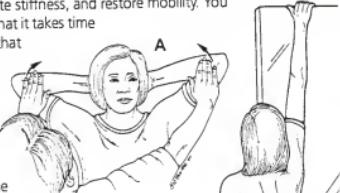
For our patients with frozen shoulder

Exercises to stretch the shoulder

The exercises shown in this guide can help stretch the shoulder joint, alleviate stiffness, and restore mobility. You should set aside 45 minutes, three times a week, to do them. Keep in mind that it takes time to achieve results; however, after 4 to 6 weeks of exercise you should notice that you are having less pain and should be able to move your shoulder about more freely.



1 Stand with your shoulder blades against the wall and hands clasped behind your head. Quickly move the shoulder joint by pinching your shoulder blades together until your elbows touch the wall (A). An assistant can help if necessary.

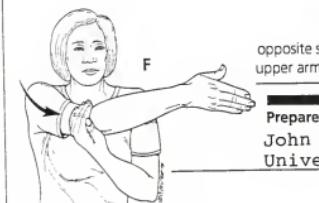


2 Reach up and grasp an overhead support or door. Then flex at the knee, using your body weight to pull on your stiff shoulder (B). Perform this exercise with quick stretching movements.



3 Reach behind your back, grasp your hand on the side of the stiff shoulder, and pull upward toward the opposite shoulder blade (C).

4 Stretch your arm upward in an overhead reach (D). You can assist with the opposite arm if this makes it easier.



5 Move the hand and forearm on the affected side away from your body. Perform this movement against the resistance offered by an elastic band that is held against your chest in the opposite hand, as shown in the illustration (E).



6 Stretch the affected shoulder in a cross-body reach by moving the wrist toward the point of the opposite shoulder. If you need assistance, press on the upper arm with your opposite hand, as shown here (F).

Prepared by

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University of Washington

Special instructions for you: If you have any questions, call this office:



The 2-Minute Lifesaver

One simple move that can stave off heart disease, diabetes, even cancer—without special training, gear, or extra time

Sitting down? Get up—right now! Walking away from your chair every half hour while you're at work or at home watching TV or checking out the new espadrilles at zappos.com sounds like the world's easiest prescription. It is—and it just might save your life.

A recently discovered health threat—uninterrupted butt-in-chair time—boosts your odds of cancer, heart disease, and diabetes. In one American Cancer Society study, women who were sedentary for six-plus hours daily—regardless of how active they were at other times—had a 34% higher risk of dying during the 11-year

study period than those who stayed seated for less than three hours. There's a weight-loss payoff, too: In one study, Genevieve Healy, Ph.D., a pioneering "inactivity researcher" at Australia's University of Queensland, found that people who took more small, low-intensity breaks throughout the day (really tiny, like walking to the printer) were slimmer than long-haul desk jockeys. The breaks don't have to be time-consuming—even one to two minutes is beneficial—but they should be frequent, every half hour or so. And you do need to move your legs: The act of standing and walking contracts the larger muscles of your legs and back, which activates an enzyme that cues muscles to take in fat and sugar from your bloodstream, Healy explains. □

HOW TO BUILD MINI-BREAKS INTO YOUR DAY...

Beyond the usual—popping over to a colleague's office instead of e-mailing her, taking the stairs—try these:

- STAND UP to use the phone. Your body works harder—maybe 30% more—when you're on your feet. Pacing is even better.
- GET RID OF THE WATER BOTTLE on your desk and walk over to the cooler.
- GO INTO THE CLOSET Do some squats while you're retrieving supplies. Need a book from a top shelf? Stretch both arms up, lean left, lean right, and then come back to center to retrieve it.

...AND INTO YOUR NIGHT

- TURN OFF THE TV Almost anything you do instead will be healthier than plopping down for more *CSI* reruns. Bonus: a 2009 study found that overweight people who cut their TV viewing in half burned an extra 120 calories per day. Or:
- WATCH AND WALK Think of commercials as workout time, suggests UCLA professor of public health Toni Yancey, M.D. March in place, haul out the resistance bands, or dance.
- GRAB A BROOM Use your movement breaks to sweep the floor or dust the windowsills. You—and the house—will be in better shape. —Sari Harrar